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**A NEW AND RAPID METHOD OF DEALING
WITH INTRA-LIGAMENTOUS FIBRO-
MYOMATA.**

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So satisfactory has become our technique in removing the diseased uterus that there is apparently not much room left for improvement. Any modification must be trivial; but the one I offer for trial has proved of such value to me that I am induced to publish it. In removing intra-ligamentous fibromyomata three elements are present which do not require the surgeon's attention in ordinary cases. There is great risk of wounding the ureter. The sinuses over the tumor are huge, and give rise to disagreeable bleeding when the capsule is split, and because of inherent difficulties the operation is generally much longer than is desired.

The method I have to describe is simplicity itself, and reduces the time of operating so materially as to appeal at once to the surgeon who has dealt with these cases. These tumors imperatively demand radical procedure, and preclude the possibility of adopting any procrastinating and so-called conservative measures. If I am right in my conclusions



as to the merits and applicability of this operation, much of the incentive for Kelly's very beautiful ureteral work will be absent, even though the passage of ureteral sounds as guides were so easy of execution as to become a definite part of our routine in the treatment of these tumors.

Operation. The ovary and tube on the free side are tied off between two ligatures, which are not locked. The broad ligament of this side is then cut between these two ligatures down to a point approaching the uterine artery. The posterior cul-de-sac is now opened and the vagina entered. Through this opening the finger of the left hand is inserted. This is a great advantage, as it enables the operator to guide his Deschamps needle and to more accurately appreciate the exact anatomy of the parts. The bladder is now dissected away from the tumor, and the vagina entered in front. The uterine artery of the free side is now secured between two ligatures in the usual way. So far the operation has proceeded as in any ordinary ablation of the uterus.

The next step is to secure the ovarian artery over the intra-ligamentous nodule. So variably situated is the tube in relation to these growths that no one fixed plan can be adopted in all cases. In one of my cases, for example, the tube was very long, with a broad mesosalpinx. I tied the tube close to the uterus, then its mesentery well out over the intra-ligamentous nodule. The mesosalpinx was then cut to the side of the uterus, the ovary and outer ligature being left over the tumor and never removed at all.

The really important step is the next. We have controlled both ovarian vessels and the uterine artery on the free side. The vagina is entirely dissected from the cervix before, behind, and on the free side. The uterus remains attached by the intra-ligamentous nodule to the broad ligament, the vagina and the pelvic floor. Heretofore it has been the custom to split the capsule of the tumor above and shell out the nodule from between the severed folds of the broad ligament. In doing this there is much time lost, a good deal of hemorrhage developed from the large sinuses that cover these nodules, and very often has the ureter been wounded. This latter structure may lie beneath the nodule, over it, in front of it, or even posteriorly. We never know just where to find it, and there is always great risk of wounding it. There is, however, one spot in which it is never found, and that is directly against the cervix, in the sulcus formed by the junction of the tumor and the uterus. The position of the uterine artery to those growths is fairly constant. Usually it lies beneath the tumor. Should the nodule spring from below the internal os, in all probability it would cause complete obliteration of the uterine artery, for the periphery of these growths is against the internal iliac artery from which the uterine artery springs. I have never met with such a case. All the specimens I have examined showed the uterine artery entering the uterus below the tumor. Discovering this, and in order to save time, as well as to avoid splitting the capsule of the tumor, I conceived the operation which, in three cases, I have successfully carried out.

The uterus having been freed, as described, it is tilted far over to the involved side by an assistant, and the large Deschamps needle is passed through the vaginal mucous membrane, so as to sweep around all the tissues between the vagina and the tumor. Great force is necessary, as the needle must hug the cervix closely, and must pass right up to the tumor. It is made to emerge into the vagina, and the uterine artery is tied by one ligature. The tissues are cut close to the cervix up to the sulcus, between the tumor and the cervix. It is now a perfectly easy matter to peel the fibroid out of the broad ligament with the fingers alone. It will come out of its bed as easily as a mandarin-orange can be divested of its rind. Apart from the absolute freedom from any danger to the ureter, this procedure will commend itself to the surgeon as most valuable in that it will shorten the time of operation very materially. It will not be necessary to ligate veins in the broad ligament or to suture the rent made in it. It renders most easy an operation heretofore very difficult and fraught with great danger to the patient, owing to hemorrhage and the risk of wounding the ureter.

If the tube is spread out over the capsule it may be tied close to the uterus, and left in the body with the capsule.

A further advantage of this operation is the ability to render all raw surfaces extra-peritoneal.

The ligatures on the uterine arteries are left long and turned into the vagina. The vagina is packed with iodoform-gauze in such a way that its upper end is as high as the cavity in the capsule.

The great point, let me repeat, is to secure the

vessels above and below the tumor close to the uterus, and *before* enucleation is begun. When the enucleation is made it is from below, and the tumor is shelled out of an intact capsule, without bleeding, as the attachment of the broad ligament to the tumor is very loose. At most, five ligatures are needed.







